WELLBEING INSTITUTE NEW CLIENT INFORMATION

Date: **Referred By:**

Name *(Last, First, M.I.):* ☐ M ☐ F | **DOB:** **SS #:**

Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Partnered ☐ Separated ☐ Divorced ☐ **Name and Phone # of Spouse/Guardian:**

Address | **Phone #** H: C/W:

Email:

Profession: Employer: ☐ Self-Employed

INSURANCE/PAYER INFORMATION

Name of Insurance career:	☐ Self-Pay ☐ UHC ☐ CIGNA ☐ AETNA ☐ HEALTHNET ☐ Others_______________		☐ **Copay (for Specialist/SP/SPEC) $**
ID & Group #	☐ ID #	☐ Group #	
If you are not the primary card holder:	☐ Name of Primary Card Holder:	☐ DOB	☐ His/Her Employer:

For my psychiatric care, I authorize Wellbeing Institute Providers to communicate with the following party: ***(No information will be released without written consent)***	☐ Parents	☐ Spouse/Partner	☐ My PCP (Dr.)
	☐ My Therapist	☐ Other Relatives	☐ Others (Specify)

I read Wellbeing Institute policy listed below and agree to comply with it. I take full responsibility in case of non-compliance.

I hereby give my consent for medical treatment by my physician(s) or other care provider(s) at Wellbeing Institute, I understand that should I require services in my doctor/provider's absence, this consent is transferable to the covering physician/provider as designated by my doctor/provider, or to other services/hospitals in the nearby area that is available on urgent/emergent basis.

Initial:_________

I understand that developing a treatment plan and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process. I understand that Wellbeing Institute providers keep minimal information in my medical/psychiatric records in accordance with the recommendations of the American Psychiatric Association and the American Psychoanalytic Study Group. This is because the effectiveness of psychiatric treatment has been shown to be dependent on true confidentiality. I understand that no promises have been made to me as to the results of treatment or of any procedures.

*Initial:*_________

I consent to the ongoing release of verbal or written communication between my doctor(s)/care provider(s) at Wellbeing Institute and my other physician(s), therapist, my spouse/significant other and my parents. I hereby authorize the physician/provider to release any information acquired in the course of my examination or treatment to my insurance company and /or Utilization Review Organization contracted by my insurance company. I authorize that messages may be left for me regarding appointment reminders or instructions regarding my care. I acknowledge that telephone calls from my physician(s)/provider(s) may be returned by cellular phone. I may revoke consent for any of all of the above chosen party at any time in writing.

*Initial:*_________

Financial Policy Insurance: Payments for services are due at the time that services are rendered. Wellbeing Institute collects deductibles, co-payments and co-insurance that may be paid with cash and check. All balances not paid by insurance are due within **15 days**. The balance will have interest accrued on 18% annual rate (1.5% per month). It is my responsibility to know my insurance policy benefits and to set up a case if pre-authorization is required. I hereby authorize my insurance benefit to be paid directly to Wellbeing Institute. All personal balance over 20 days will be sent to a collection agency. **$25** fee will be charged for all returned checks *in addition to* the bank extra charges and interest accrued since then, and all services in the future will need to be paid in cash. The accompanying parent or adult with a child is responsible for the full payment at time of service. In case of divorce, it is the parents' responsibility to work out the payment of their child's medical care between the two parents.
*I agree to give **48 hour notice** to reschedule or cancel appointment, or pay the **$150 missed appointment fee** for each appointment missed.*
I agree to pay for medical record copying and delivery expenses, time to spend for preparation of documents, letters of employment and legal purposes, disability, FMLA or other paperwork, pre-authorization effort with insurance companies for services or medication that are needed for my care, as well as excessive use of after hour calls.

*Initial:*_________

Stimulant Medication: Given the fact that DEA and State have particular rules in regulating stimulant medication prescribing activity, I agree to be seen in person for such a prescription for 30 days supply of medication, and will return to Wellbeing Institute when I have at least ONE WEEK medication supply.

*Initial:*_________

Signature: ____________________________________Date: mm/dd/yyyy ______________ Signed by: __ Client __ Guardian __ Personal Representative

Name ____________________ Date ____________

Symptom Checklist

(Check all that apply; then circle up to 10 items which are especially bothersome to you)

1) Please check any of the following which may have been particularly stressful to you:

Recent	Past	
❑	❑	Job related stress
❑	❑	Marital conflict
❑	❑	Death or loss of loved one
❑	❑	Move to a new place and losing contact with friends or family
❑	❑	Conflict with children
❑	❑	Children with behavior problems
❑	❑	Conflict with parents or extended family
❑	❑	Feeling stressed due to recalling memories of an earlier time of trauma or stress in my life
❑	❑	Family member with an alcohol or drug problem
❑	❑	Being abused by someone
❑	❑	Financial pressure

2) Any of the following symptoms for <u>most of the day, nearly every day, for periods longer than several days at a time:</u>

Recent	Past	
❑	❑	Depressed or sad mood
❑	❑	Loss of interest or pleasure in things I'm normally interested in
❑	❑	Difficulty falling asleep
❑	❑	Difficulty staying asleep or waking up too early (Average number of hours your are sleeping per night? ____________)
❑	❑	Sleeping too much
❑	❑	Increased appetite/Weight gain (lbs.____)
❑	❑	Decreased appetite/Weight loss (lbs.____)
❑	❑	Fatigue/Poor energy level
❑	❑	Decreased activity (work, social, physical, sexual)
❑	❑	Poor concentration or slowed thinking
❑	❑	Thoughts of suicide
❑	❑	Excessive feelings of guilt or worthlessness
❑	❑	Decreased sex drive or interest

3) Any of the following symptoms, <u>more days than not, for months at a time:</u>

Recent	Past	
❑	❑	Excessive anxiety or worry for no good reason
❑	❑	Trembling, twitching or feeling "shaky"
❑	❑	Muscle tension or muscle aches
❑	❑	Easily fatigued
❑	❑	Dry mouth
❑	❑	Dizziness or lightheadedness
❑	❑	Nausea, diarrhea or other stomach problems
❑	❑	Frequent urination
❑	❑	Feeling keyed up or on edge
❑	❑	Irritability
❑	❑	Trouble falling or staying asleep

4) Panic attacks (any period of extreme, increased anxiety lasting from a few minutes up to several hours) with any of the following symptoms:

Recent	Past	
❑	❑	Panic attacks/anxiety attacks
❑	❑	Persistent worry that I will have a panic attack
❑	❑	Heart pounding or racing heart
❑	❑	Trembling or shaking
❑	❑	Sweating
❑	❑	Choking
❑	❑	Nausea or stomach problems
❑	❑	Feelings of unreality
❑	❑	Numbness or tingling sensations
❑	❑	Feeling of smothering or shortness of breath
❑	❑	Fear of dying
❑	❑	Fear of going crazy or doing something uncontrolled
❑	❑	Chest pain or discomfort
❑	❑	Dizziness, unsteady feelings or faintness
❑	❑	Flushes, hot flashes or chills
❑	❑	Avoiding situations or places that may cause panic or severe anxiety

5) Any of the following symptoms for <u>most of the day, nearly every day, for more than four days at a time:</u>

Recent	Past	
❑	❑	Euphoric or "high" mood
❑	❑	Irritable mood
❑	❑	Decreased need for sleep without feeling tired
❑	❑	Increased energy level
❑	❑	Increased activity (work, social, physical, sexual)
❑	❑	Thoughts speeded up or racing thoughts
❑	❑	Much increased talkativeness or being much more socially outgoing
❑	❑	Making decisions too impulsively
❑	❑	Going on spending sprees

6) Check any of the following relating to your alcohol or drug use:

Recent Past

- ❑ ❑ I've felt alcohol or drugs were causing a problem for me
- ❑ ❑ I have felt guilty about my use
- ❑ ❑ Others have annoyed me about my use
- ❑ ❑ I have had a desire (or made unsuccessful efforts) to cut down or control my use
- ❑ ❑ I've tried unsuccessfully to control my use
- ❑ ❑ I've used alcohol or drugs more often or in larger amounts than I intended
- ❑ ❑ I've had to increase my use of alcohol or drugs to get the desired effect
- ❑ ❑ I've had problems with withdrawal (shakes, nervousness, insomnia, etc.) when I've cut down or stopped using alcohol or drugs
- ❑ ❑ I've been to a meeting of Alcoholics Anonymous or Narcotics Anonymous

7) Any of the following disturbances in eating or maintaining normal weight:

Recent Past

- ❑ ❑ Insistence on maintaining body weight below expected for age and height
- ❑ ❑ Intense fear of gaining weight or becoming fat even though underweight
- ❑ ❑ I feel "fat" even when others see me as underweight
- ❑ ❑ Eating binges
- ❑ ❑ Feeling of lack of control of eating during eating binges
- ❑ ❑ Vomiting or using laxatives to prevent weight gain
- ❑ ❑ Being overconcerned about body weight and shape

8) Check any of the following that apply:

Recent Past

- ❑ ❑ I tend to do things on impulse which end up being damaging to me or others
- ❑ ❑ I have mood swings (depression, irritability, anxiety, anger) lasting up to several hours
- ❑ ❑ I have tried to commit suicide
- ❑ ❑ I have made cuts, burns or other injuries to myself without wanting to kill myself
- ❑ ❑ My relationships always seem to work out wrong
- ❑ ❑ My mood often shifts from being either overconfident to having very low self esteem
- ❑ ❑ I have a hard time sympathizing with others' pain
- ❑ ❑ I often feel others do not understand me
- ❑ ❑ I tend to get very hurt or angry when I am criticized or rejected by someone
- ❑ ❑ I tend to need a lot of reassurance or approval from others
- ❑ ❑ I am very concerned about my appearance
- ❑ ❑ Others often expect too much of me

9) Any of the following at any time:

Recent Past

- ❑ ❑ Hearing voices that sound real even though they are not actually there
- ❑ ❑ Vivid voices in my head that do not seem like my ideas
- ❑ ❑ Feeling that others might be putting thoughts in my head
- ❑ ❑ Feeling others might be able to read my thoughts
- ❑ ❑ Others feeling I am too suspicious or paranoid
- ❑ ❑ Feeling others might be talking about me

10) Any of the following problems relating to a past severe trauma or stress:

Recent Past

- ❑ ❑ I have had an experience which was so traumatic that nearly anyone would have been seriously stressed by it
- ❑ ❑ History of relatives hurting me physically or touching me in sexual areas
- ❑ ❑ History of unwanted sexual contact
- ❑ ❑ I have memories or dreams of a stressful event that I have trouble putting out of my head
- ❑ ❑ I sometimes have flashbacks of past events; or I act or feel as though I am re-living a stressful event from the past
- ❑ ❑ I try to avoid situations or people that remind me of a severely stressful event in the past

11) Any of the following obsessions or compulsions:

Recent Past

- ❑ ❑ Excessive doubting; or repeated, forced unreasonable thoughts, images, or sounds that I cannot get out of my mind
- ❑ ❑ Urges to check things, wash things, or count repeatedly
- ❑ ❑ Excessive concern about coming into contact with germs or dirt
- ❑ ❑ Excessive concern with right/wrong or morality
- ❑ ❑ Excessive need for things to be exact or symmetrical

Patient Name: ______________________
Date: ______________________

Comprehensive Assessment Questionnaire
Presenting History

What is the main problem that caused you to seek help?

____
____
____
____

Why did you decide to seek help now?

____

Describe the main symptoms that are causing problems for you:

____
____
____

When did the problem first begin? ____

Describe any stresses in your life that may have contributed to the problem:

____
____

Have you had a similar problem in the past? _Yes _No. If so, please describe the episodes and the dates they occurred.

____

Where you treated for this problem? __Yes __No. If so, please describe the treatment you received.

Has this problem caused you to experience any decrease in your ability to function in the following areas?

School Performance__ Work Performance__ Relationship with spouse/significant other__
Functioning as a parent__ Social Life__ Ability to manage chores at home__

Past Medical History

Please list all medications you are currently taking:

Medication	Dose	Start Date (MMYY)

Allergies to Medications ________ Type of Allergic Reaction ______________________

Past Mental Health History:
Please list any Psychiatrist/Psychologist/Therapist you have seen previously:

Name	Date of Treatment

Medications prescribed in the past?

Medication	Date	Response

Have you ever been in a psychiatric hospital in the past? __Yes __No. If so, please list the facility and the dates of treatment.

____

____

Have you ever attempted suicide? __Yes __No If yes, please describe the nature of the event and the date(s) of occurrence.

____

Substance Use:
Do you use any of the following substance?

Tobacco __ Caffeine__ Alcohol__ Marijuana__ Cocaine__ Amphetamines__
LSD__ Heroin__ Pain Killers__ IV Drug Use__

Have you ever felt that you were abusing drugs or alcohol? __Yes __No
Have you tried to stop drinking? __Yes __No. Have you ever attended AA or NA? Yes__No__

Medical History:
Who is your primary care physician? ______________________________

What medical problem do you have? What current medication are you taking for the treatment?

____

Women only:
Are your periods regular? __Yes __No. Method of contraception __________
How many pregnancies have you had? ____________ Are you currently pregnant? __Yes __No
Are you planning to become pregnant in the near future? __Yes __No.

Family History

Psychiatric History (List any blood relative who have had emotional problems—such as depression, manic depression, alcoholism, drug abuse, suicide, schizophrenia, anxiety problems)

Problem	Relative	Maternal (M)/Paternal (P) side	Hospitalized

Were your parents divorced? __Yes __No If so, how old were you ________ Who did you live with after the divorce? ____________ What was your relationship with the stepparent(s)? ____________

Were you ever subjected to any type of abuse? (emotional, verbal, physical, sexual). If so, describe the events. ____

Educational/Occupational/Social Histories

Are you currently working? __Yes __No What is your occupation? ______________________
Where do you work? __________ How long have you been there? ______
Are you satisfied with your job? __Yes__No If No, please explain______________________

Are you graduated from __High School __College __Graduate/Professional School__
What is your highest degree? _____

Date of Birth: ___________ Current Age ________ Place of Birth ________________

Are you currently __Single __Married __Divorced __Widowed __Other?
How long? ________________ What is your sexual orientation? ______________